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ABSTRACT

This document is the second volume of a series of reports on the Community Mental Health Center (CMHC) Survey project undertaken to assess the impact of the Alcohol, Drug Abuse and Mental Health Services block grant program on the delivery of mental health services to older persons. Section I of this volume presents excerpts from the reports on the site visits to CMHCs and Area Agencies on Aging (AAA) which were conducted to obtain information about the impact of the block grant on CMHC programs and age-related services, and on the nature and extent of interagency contact and cooperation between CMHCs and AAAs. Section II contains the mail/telephone survey questionnaire which was completed by 233 CMHCs in 41 states and which requested information on the impact of the block grant, specialized aging programs, funding sources, the client population, services provided to older clients, and professional and support staff. Section III presents guidelines for site visit interviews with CMHCs, AAAs, and with clients and/or significant others. Section IV provides the levels of statistical significance for the data comparisons in the project. (NB)

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Mental Health Services for the Elderly:

Report on a Survey of Community Mental Health Centers

Volume II

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Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging

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The Retirement Research Foundation

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OF THE 1981 WHITE HOUSE CONFERENCE ON AGING

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Mental Health Services for the Elderly:

Report on a Survey of

Community Mental Health Centers

Volume II

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This is the second volume of a three volume report. Volume I presents the introduction and background to the survey, the results of the survey of Community Mental Health Centers, brief summaries of the site visits to community Mental Health Centers and Area Agencies on Aging, and recommendations for federal, state and local reforms to improve the delivery of mental health services to older persons.

Volume III, to be published in Fall 1985, will present the two year follow-up resurvey of Community Mental Health Centers to determine the on-going impact of the Alcohol, Drug Abuse and Mental Health Services block grant on the provision of mental health services to older persons.

Volumes I and III may be obtained by writing to:

The Action Committee to Implement the Mental
Health Recommendations of the 1981 White
House Conference on Aging
1200 Seventeenth Street, N.W.
Washington, D.C. 20036

Section I

SUMMARY OF SITE VISIT INTERVIEWS

a. Community Mental Health Centers.

b. Area Agencies on Aging.

SUMMARY OF COMMUNITY MENTAL HEALTH CENTER INTERVIEWS

Impact on General Program

In general, how has implementation of the ADMS block grant program affected this Center?

In response to this question, six CMHC's confirmed their earlier reports on the questionnaire that the block grant had a negative impact on programs in their centers, and one CMHC reported a mixed response, of both positive and negative effects. Four CMHC's confirmed their earlier reports on the questionnaire that they had no significant reductions in their programs due to the block grant. One of these Centers stated, however, that they have had to reduce non-clinical services due to the decrease in block grant funds, and another Center reported that their overall level of funding was maintained only due to an extensive lobbying effort, and they were unsure whether full funding will be sustained in the next budget year.

Of the six Centers reporting a negative effect on their programs due to the block grant funding reductions, the following statements from the site visit reports are illustrative of the comments received:

> "Before the block grant program, Detroit East [Michigan, CMHC] had 42 full-time professional staff members and an overall budget of $2.6 million. After the block grant program, Detroit has 16 full-time staff and an overall budget of $2.2 million. Detroit East's loss of $2 million federal CMHC grant was replaced only by $1.25 million in block grant funds. They also lost a $60,000 federal community support/aftercare demonstration grant. The State has only increased support of the CMHC by $300,000 and the county by $50,000. Therefore, the Detroit East CMHC has lost a significant amount of funding."

> "There have been a number of specific negative impacts on Older Adult Services [Billings, Montana] as a result of the block grants:
>
> 1. The CMHC originally brought older persons into the Center for group services, which was considered a very desirable arrangement. In order to do this, the Center had a special transportation contract for pick up and return of the clients. This transportation service was eliminated because of budget reductions, and the group is now held at a nursing home, for persons who are residents there. This eliminates from service a number of people who previously profited from it.
>
> 2. The Older Adult Services began with Conversion money. As Conversion Grant monies dried up, staff was not replaced. Originally there were seven staff members; now there are three. The loss has been in the rural portions of the catchment area.

The block grant has had considerable impact on the CMHC. The Center is seeing ten percent fewer people, because they no longer have the staff complement of the pre-block grant days. They are seeing more patients are are seriously ill, and they are seeing them more frequently. The Center lost its Medical Consultant, who was a geriatric specialist . . . the job training program was eliminated. While consultation and education services were not reduced, outreach services in their rural office was. The Center used to try to make home visits, now all contacts take place in the office.

There has been a token allotment to each CMHC of $12,000 from the block grant for preventive services. The Billings CMHC spent $187,000 to $200,000 for preventive services in 1982. These services have been reduced from pre-block grant levels, and are threatened even further if the block grants continue."

"Since the implementation of the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant program, the overall [Port Huron, Michigan] CMHC program has suffered a 6% reduction in funding and a 4% reduction in staff."

The mixed response to the question was from the Oxford, Mississippi CMHC:

"'The advent of the block grant gave us a bit more stability in terms of federal support. We can't rely completely on block grant funds, but it provides a fair base.' By stability is meant not more money but greater certainty."

Of the four Centers reporting no negative impact on their service programs due to the block grant method of funding, the following statements are illustrative:

"'Block grants have had virtually no impact on us [Muscatine, Iowa CMHC]. We are somewhat unique in that we have never relied heavily on Federal dollars. As a result we have great city and county support.'"

"The respondent [Brownwood, Texas CMHC] had feared the block grant system was going to affect them, but instead it turned out that they received an increase in federal funds. The state MH/MR Agency had the authority to disburse the funds and made a determination to fund those agencies already receiving federal funds and to fund at the level the federal government provided."

"The implementation of the ADMS block grant program had not, at the time of the interview, had a negative effect on the [Bronx, New York] Center. However, staff was concerned that although they had fended off cuts with an active campaign for the first and second years of the block grants, they might not be so successful next time."

Since the Center began receiving ADMS block grant funds, has the composition of its client population changed with regard to age, race or ethnicity, sex or employment status? If so, in what way and to what extent?

Only one CMHC reported any change in its client population attributal to the block grant. The Billings, Montana CMHC reported:

> "Services to Native Americans have been reduced over the state. However, while the Center has seen some Native Americans in the Outpatient Service Department, they do not see any in Older Adult Services."

Has the general reduction in block grant appropriations resulted in the development or exacerbation of any problems at this Center?

Eight Centers reported that there were no specific changes due to the block grant system of funding. Three Centers did report specific changes related to the block grant, and gave examples of the problems they have experienced:

> "The agency [Braddock, Pennsylvania] will have to limit services to handling only the most severe cases on a priority basis, and referring less severe cases to private practitioners and local agencies. The Agency has begun to incur marked increases in client waiting lists, with the average waiting period up from two months to three months for service."

> "The Center [Billings, Montana] is feeling the pressure to charge more people higher fees."

> "This reduction [in Federal support] has resulted in a reduction in services to those individuals who are only 'moderately impaired,' and increased delay between the time when persons apply for service and it is begun (for the aged this is now up to a six week delay), and a reduction in support services (primarily transportation services) to the mentally disabled who reside in the rural area of the county [Port Huron, Michigan]."

The deinstitutionalization movement has generally resulted in increased demand for outpatient services nationally. Has this Center found this to be true within its catchment area? If so, what types of populations have increased within its caseload as a result of deinstitutionalization?

The deinstitutionalization movement has had a direct impact on only two of the CMHC's visited. The states have taken the initiative in providing for the care of the chronic mentally ill, and many elderly state hospital mental patients are placed directly into nursing homes. The following statements are representative of the comments received on this question:

In Spokane, Washington, "only 5% [of patients in the In-home Care Management Program] had ever had any prior outpatient or inpatient psychiatric care."

"Deinsitutionalization is decreasing. The Center [Billings, Montana] picks up on discharged patients. People come to the Center for short-term hospitalization (instead of to the state hospital). Then they are discharged and put on maintenance. This is especially true for older patients, who represent 11% of the contacts on the Center's inpatient service."

"'This means that we [Oxford, Mississippi CMHC] are treating more and more people who are really sick. The 21-day cures are what we get: something legal has to happen for a person who has been civilly committed on the 21st day so they have to stay longer or be sent home. They very often are not stabilized on medicine and become our clients . The caseload is much higher; our caseload is 30-40% after-care or mentally ill combined with poverty. The hospitals have decreased admissions 4%, length of stay is shorter. MHC's clients have increased 40%.

We have always served poor folks, this is a poverty area. Between '81 and '82 the caseload of elderly increased 12%, for youth a 35% increase. There was an initial increase of elderly clients five years ago when the hospitals started deinstitutionalization but this leveled off as they cleared out.'"

Impact on Aging Population

Nationally, only 4% of the client population of Community Mental Health Centers is elderly, although 11% of the general population is over sixty-five. What does the Center preceived to be the major reasons for under-service of this client population? Has the ADMS block grant program had any impact on the provision of mental health services to older people at this Center?

Ten of the Centers were in agreement that older persons are an underserved population, though they had different assessments about the reasons why this occurs. The major reasons for underservice to the elderly included: the stigma attached to mental illness, "rugged individualism" and a reliance on the family for support, lack of transportation to the Centers and professionals not making home visits, Center priorities favoring other client populations, lack of agency interest and expertise in treating the elderly, and budget reductions. One CMHC reported the aged to be fully served by the Center. The following comments are illustrative of the responses received:

"A little over 10% of the clients seen are elderly [Billings, Montana CMHC]. The catchment area has about 11.3% aged, which is a greater percentage than for the state as a whole. The most pressing needs are for out-patient services for individuals (priority #1), day

treatment in-patient services for the chronically mentally ill (priority #2), and out-patient group services (priority #3). The Rainbow House, and the Day Treatment Center of the CMHC, has not changed since the block grant. It has been given priority to maintain the services by the Center.

The number of aged seen by the Center is increasing; the population in the area is aging. The aged do not 'beat down the Center doors'; staff do a lot of out-reach. Staff go to senior Centers, staff sit on community boards, etc. They build relationships with other agencies, and their excellent network results in the referral of elderly clients.

Only about 4% of the clients were aged before the Center did outreach, and they believe that outreach is the only answer to engaging the aged in service. The attitude of the elderly themselves is that 'mental health services are o.k. for other people'. They interpret getting help as getting medicine and are not familiar with the 'talking cure.'"

"'Since we [Muscatine, Iowa] hired our older adult specialist our case load of elderly has gone from 4% to 7% in the last year. This was not directly related to the block grants however. I don't really see them as being directly related.

There are from our prospective, several reasons why the problem of underservice exist. First of all, the stigma that older people associate with mental health/illness makes it very difficult to attract them or service them. Frequently we work "undercover" with the AAA as the identified agency in order to help an elderly client. Transportation and lack of awareness of what services are available also contribute to it. From the Centers prospective, older clients do have a negative image, e.g. they don't improve, are all chronics, and so very few counselors have actual geriatric training. I think one of the biggest fears is that diagnostics (functional vs. organic) are so difficult and complicated.'"

"He [Brownwood, Texas CMHC] quoted several reasons: 1) greater reliance on ones family and 2) the attitude among the elderly about mental health services; that of rugged individualism 'we will take care of our own and don't government agencies.' Also, he cited the conservatism of the area. The facts of good family support and less pressure in daily life contribute to ones ability to be ruggedly individual. The block grant has had no impact on the number of elderly served."

The Hispanic elderly [Bronx, New York CMHC] confuse mental health with mental illness, even when they may need service for treatment of illness. They may be referred, and when they come and see this as a

mental health center they don't want to continue. There is a stigma about mental illness, and there is also a stigma about getting something for nothing; they are people with pride.

The staff felt there were several factors contributing to underservice of the aged population by mental health programs. Knowledge of service, and the ability to work the system are important. In the Centers catchment area, Blacks have a better economic and political position, and they know how to work within the system.

The need for home visits was mentioned as a problem. The Center did have a mobile unit that did an excellent job, but with funding cutbacks (prior to the block grants) the mobile unit was lost.

There is not enough outreach to the homebound. Funding is structured so as to tie the Center to office visits. Agencies make little effort to engage the elderly in treatment; they tend to just medicate them and send them home. Also, staff are not interested in serving older people. There should be some specific fund for mental health services for the elderly, because unless there is, services will go to younger, 'more interesting' clients. There is also not enough coordination among agencies, and an expansion of services. There is not adequate service if the elderly do get to them."

"Despite the fact of this 'underservice' to the older citizens of the community by the [Naples, Florida CMHC], the CMHC Executive Director and the Gerontology Specialist know about the needs of the older residents and are trying hard to be responsive. However, limited resources, a state priority on the chronically mentally ill, and a local priority on children have made it impossible to put additional resourses into serving the aged."

Has this Center conducted an assessment of the need for mental health services among the elderly in its catchment area? If so, what is the prevalence of mental illness among the elderly in this catchment area? What did the assessment reveal to be the most common mental health problems among older people in the community?

Only three of the Centers had conducted a recent needs assessment. While the other Centers had not conducted a formal assessment, they could report on the types of client problems they were treating. They used estimates from government sources, in some cases, to project an informal reading of the mental health needs of the elderly in their catchment areas. The following comments are a illustrative of the responses received:

The Oxford, Mississippi CMHC conducted a needs assessment survey in 1977: "This was done preparatory to writing the conversion grant. The most common problem with elderly - managing them in the home. Then depression and alcohol (alcohol among males). Drug problems - OTS among females usually. Schizophrenia - not a large number."

The Muscatine, Iowa CMHC had also conducted a recent survey: "'The prevalence rate (really an estimate) would be that 15-20% of the elderly were in need of our services with depression being the most prevalent problem. We are also involved with drug abuse/misuse problems of the elderly. However, our substance abuse/alcohol program does not serve any elderly at this time.'"

"Their [Bronx, New York CMHC] most commonly seen mental health problem is depressive disorders. Social maladjustment is #2, schizophrenia is #3. They see a few organic brain syndrome cases, a few neuroses, and a few anxiety disorders. They do not see any drug disorders (although they are very alert to over medication) and very few alcohol disorders (these are referred internally to the Alcohol unit)."

"The most common problems sited [Braddock, Pennsylvania CMHC] were clients with drug misuse and/or alcohol problems and clients requiring supervised living arrangements.

Although the agency has not conducted a needs assessment, it is assumed that the county-wide needs estimates of 18-24% are applicable at the local level. The Center estimated that the majority of the older client population was chronically impaired. The major problems experienced by non-chronic clients was depression."

This Center has indicated that is has a specialized aging program. Specifically, what services are provided as part of the program?

Nine Centers reported having specialized aging programs, though one of these programs was operated by only one full-time staff person, and another by one coordinator on a half-time basis. The amount and types of services offered in these programs varied between Centers, as illustrated by the following descriptions of aging programs:

"The In-Home Case Management Component [Spokane, Washington CMHC] is mandated to maintain the independence of the elderly, prevent premature and/or unnecessary institutionalization as well as improve their quality of life. The staff of this component consist of ten case managers, a pharmacist/case manager, two part-time psychiatrists, two field supervisors, a program coordinator, and a resident physician who provides four hours a week of in-home evaluation and treatment. In addition to the In-Home program, the Centers 'Gatekeepers' program has significant value. The Center has implemented a strong outreach effort to locate the high-risk target population. Gatekeepers includes the following: appraisers from the county assessors's office, apartment and trailer court managers, postal carriers, meter readers, grocery store clerks, pharmacists, church staff, and ambulance companies, etc. Each case manager within his or her geographic area contacts such persons to aid in identifying high-risk elderly who would not self-refer or have anyone to act on their behalf."

"'We [Muscatine, Iowa CMHC] provide outpatient therapy, outreach, case management, and consultation and education (C&E) services. We are not connected with partial or in-patient services directly. It is an essentially one person older adult program. The older adult specialist provides training and consultation to three of the nursing homes in our area, and on a limited basis will provide therapy to the patients. She also works with the AAA and their social worker. She made presentations at nutrition sites and made home visits with the AAA social worker. She also consults with our counselors when they encounter an aging belated problem with their clients. Finally, we have direct contact with a widowhood and an Alzheimer's support group. In these settings we provide C&E.'"

"Rainbow House, the Day Treatment Center of the [Billings, Montana] CMHC, has not changed since the block grant. It has been given a priority to maintain the service by the Center.

One of the largest groups requiring social work services in the home are the aged living in co-ops and group homes, especially those who have been released from Warm Springs Hospital. These clients need help with living skills and with linkages to social services. A problem is that social work service, while it gets some reimbursement from the state, is not is not reimburseable under Medicare or Medicaid. Thus, it is difficult to provide and/or increase this service, because there is no current possibility of reimbursement for it.

Alcohol is a latent issue. The Alcohol Unit would see aged individuals with an alcohol problem.

The Center staff is very sensitive to the abuse of prescription and over-the-counter medication. They see a lot of this, and they do home visits to check on it and to be certain that it is or isn't an issue."

"The types of service activities of the gerontoloy specialist [Naples, Florida CMHC] include: Information and referral, outreach and in-home evaluation, social services, case management, interagency consultation, community advocacy, and direct counseling. The gerontology specialist reports receiving about 40-45 calls per month seeking information about how and where older persons can obtain specific services. The primary direct service of the gerontology specialist appears to be 'outreach/in-home evaluations,' done on referral of other agencies, other clients, and relatives of potential clients. A major focus in the to above-mentioned activities is assessing the clients needs for various social services and linking the older clients to these services -- particularly transportation, health care, and social activities. Case management of formal CMHC clients appears to be occupying a larger and larger percentage of the gerontology specialists time. Interagency consultation is very extensively done by the gerontology specialists."

"There are four components to the Detroit East CMHC aging program: Information and referral service, senior outreach, telephone reassurance, and nursing home consultation. The first three services are intended to provide older persons with linking to community resources so as to enable them to stay in their home longer -- delaying or decreasing the flow of older persons into institutions. The nursing home consultation services provides mental health consultation, in-service training, and program development support to the twelve contracted homes of the eighteen within their catchment area."

This Center indicated that it did have an aging program at one time. Why was the program discontiued?

Two Centers discontinued their aging programs, one due to budget reductions which resulted in the loss of their geriatric specialist, and the second due to a change in state policy no longer requiring them to maintain an aging program. The following reports describe the changes in these Centers:

"The effect of these reductions has had a particular impact on the services for older adults [Braddock, Pennsylvania]. The agency had a specialized aging program from 1980-1981, but the program was discontinued due to the layoff of the agency geriatric specialist. Because the agency no longer has a specialized aging staff, there is no specialized outreach program for older people, consultation and education contracts with community aging organizations have been, to a large extent, discontinued and the overall percentage of direct treatment services to older clients has dropped from 11% to 9% of total client services."

"'It never was a specialty clinical program [Oxford, Mississippi CMHC]. We never funneled all elderly through the elderly program - if they had an alcohol program, they went to the alcohol program. The main reason we dropped it is that the state no longer required us to have a specialty program for elderly. (We do have for alcohol, children, teenage parents, service programs like partial hospitalization.)

No plans to institute the aging program as a clinical program. When we discontinued it, we did continue it as a significant emphasis. We turned elderly service over to consultation and education. They've been out to senior centers to give information and case delivery. It made no sense to us to have a separate staff to see only elderly folks. Our staff in the small offices have to have special training in alcohol, children, etc.'"

Interaction With Other Agencies

All Centers reported interaction with other public, private and government agencies. The range and type of contact, the frequency of contact, and the cooperation between the agencies varied among the Centers. The following comments are illustrative of the interactions reported:

"The Turtle Creek Valley Mental Health and Mental Retardation Office [Braddock, Pennsylvania] has little routine interaction with Eastern Area Adult Services Office, the multi-purpose senior Center serving the mental health and mental retardation catchment area. When interagency communication occurs it is related to referrals to the MH/MR office for assessment and referrals to the aging office for home care or socialization services. There is no interagency case management system to provide follow-up on referrals."

"The Greater Lynn [Massachusetts CMHC] and Senior Service Office have a record of service coordination dating back to approximately 1976. The CMHC assigns five or six therapists and one psychiatrist to these clinics on a two day a week basis. At least one hour per week is formally set aside for staff consultation among the CMHC therapy and AAA staff. Informal staff consultation, however, is conducted between the two offices on a daily basis. A second area of interagency coordination is a telephone reassurance program, housed at the Union Hospital (CMHC) and managed by volunteers recruited and trained by the CMHC staff. A third area of coordination is a soon to be started crisis intervention program. Finally, the two agencies have undertaken some in-service training for their staff."

"The referrals for outreach come from many sources [Detriot, Michigan CMHC], including churches, family and friends of potential clients, Congressionals offices, and the Department Social Services. Both outreach evaluation and continuing outreach services are provided. The outreach workers take referral/determination forms related to many programs with them when they do an initial outreach evaluation; these include: Department of Social Services (DSS) food stamp applications, DSS security assistance determination forms, energy assistance applications, neighborhood services transportation request, homebound meal referral forms, and referral forms for their own telephone reassurance programs. The Detriot East Older Adult staff, has direct service providers, primarily have contact with direct service providers in the aging network. Contact with AAA service units appears adequate; contact with the AAA administrative/policy unit is, obviously limited."

"There is much interaction [Bronx, New York CMHC] with multi-purpose senior centers, with the Social Security Office, and with St. Barnabas, the private psychiatric hospital. There is at least weekly interaction with the Department of Welfare, Social Security, and the Citizens Advance Bureau, inpatient units in hospitals and emergency rooms, other neighborhood community health centers, and with the local hotel for seniors. There are specific liaison relationships with the state mental hospital, generals, neighborhood health Centers, senior Centers and outreach clinics. Interaction with private physicians is on a case-by-case basis.

There is a good informal network arrangement with the police. Relationships with other law inforcement agencies are also good. There is some contact with senior housing, and some with churches in the area. There is no relationship to speak of with the Department of Public Health, and there are no nursing homes in the areas.

Most relationships are close enough for contact to be initiated either way, so the nature of the interaction is usually a two way referral, and two way case management. There is clinical consultation with senior citizen groups and community agencies and health Centers, where other agencies do not have the clinical expertise. Advocacy is also two way. There is almost no contact with the Area Agency on Aging. There has not been any significant change in the interaction with aging agencies since block grant funding came into effect."

"'We [Muscatine, Iowa CMHC] have fairly direct and fairly frequent contact with: AAA, senior centers, nutrition sites, nursing homes, county mental hospital, general hospital, private physicians, community nursing service, police, Social Security Office, Office of Relief. We help with nursing home placement, hospital discharge and also spend time obtaining funds and services for older adults as part of outreach and case management. On a weekly basis we deal with the Office of Relief, AAA and nursing homes. Our Older Adults Specialist is our designated liaison person. The nature of the interactions but most typically involve direct service, clinical consultation and case management. The initial contact is usually made by them not us. If any thing the contact has increased, although again I think that it is unrelated to block grants. You have to remember that this community frequently says "no" to Federal funds.'"

"Interagency consultation is fairly extensively done by the gerontology specialist [Naples, Florida CMHC]. She has contact with all agencies and programs which regularly serve the aged; the degree or regularity of contact, of course, varies from agency to agency. The two most regular and frequent contacts are with the Our Place Senior Center (an AAA-funded program) and Goodletter Arms (a HUD-funded low-income elderly housing project). There are regular contacts with two of the four nursing homes in the community, and some degree of involvement with all four nursing homes. The gerontology specialist also has contact with the Department of Social Services Homemaker program, the Friendly Visits Program, Meals-on-Wheels, Help-on-Wheels, Able Care (in-home nursing) Service, Senior Employment Service, local citizens Mental Health Association, and the local hospice program. While the CMHC has contact with a number of AAA-funded programs, it has relatively little direct contact with the AAA (which is headquartered in a different county). The gerontology specialist is also active in community advocacy, speaking on behalf of the aged. She has, in the last two years, served on the Board of Directors of the Council on Aging and the

Board of Directors of the Naples Welfare Association, served on a committee developing a proposal for a second low-income elderly housing project, appeared on a television program about aging, spoken to an array of local groups (Masonic group, church groups, high school classes, etc.), and worked on the local Senior Citizens' Information Fair, local Prevent-a-Care fair, and several public information efforts. Finally, as time permits, the gerontology specialist provides continuing counseling for identified patients and their families; however, this latter direct service has decreased in each of the last three years."

Future Directions

Block grants are part of the Administration's inititive to shift responsibility for social programs to state and local government and to the private sector. In this state and county, will non-federal funding sources be responsive to the need for mental health programs serving older Americans? In your opinion, what agencies would be most responsive?

There was a mixed response from the Centers on how responsive they believed non-federal sources would be in replacing funds lost due to the block grant. The following comments are illustrative of their views:

"The respondent [Brownwood, Texas CMHC] said the state has already proved its willingness to approve block grant funds for the programs who were already getting money. The State is collecting 75% of what the Federal government was giving out but is itself giving out 100% of what the CMHC's were receiving. The respondent said he did not understand how they could do this. There are needs assessments being done and an awareness raising campaign going on. He could not forsee where the excess money would come from - that it is not going to come from the counties."

"'None of the non-federal funding agencies have been particularly responsive to aging programs [Muscatine, Iowa CMHC]. It is not a top priority for any particular group. However, to date I would say Mental Health Center has gotten good support, so maybe we are the ones who need to push for more aging services and I think we intend to do so.'"

"State and community responsiveness or funding sources to the need for mental health programs serving older Americans will vary [Billings, Montana CMHC]. State government is expected to be responsive, and to stress aged and ethnic minorities. County and local government are not expected to provide new money, nor are private corporations, private foundations or other private nonprofit organizations. The United Fund gives the Center no money; $23,000 was requested last year but was denied."

"None of these programs [Lynn, Massachusetts] feels that the local government or private corporations and foundations can pick the slack if there are further decreases in federal funding. The CMHC is making preparations in the event that the $400,000 block grant level is further decreased or eliminated. In this event, the CMHC plans to remove certain clinics outside the Union Hospital. This would enable direct program billings and would remove programs from the jurisdiction of the Cost Containment Act which applied only to the hospital. While cuts would probably be sustained, the CMHC director feels that it is unlikely that the aging program would be negatively impacted. However, cuts would prohibit expansion of programs, including the much needed homecare service."

"The [Bronx, New York] Center staff thought that City government would be responsive to the need for mental health programs for the aged, but that state government would not, nor would private corporations and private foundations. They would expect some response from other nonprofit organizations, churches and charities, since those had been particularly responsive to the homeless. The staff noted that many people volunteered to help with services, but there was not so much volunteering of funds."

Should the CMHC be the focal agency for the delivery of mental health services to older adults? Why or why not? If not? What would be the most appropriate agency?

There was unanimous agreement among the CMHCs that the Centers should be the focal agency for the delivery of mental health services to older adults. The following statements are illustrative of the comments received:

"The respondent [Brownwood, Texas] feels that the CMHCs should be the focal agency for the delivery of mental health services. He said that definately they are not prepared to handle the 22% of the elderly in the population, there are not enough funds available."

"'I feel that we [Muscatine, Iowa] have the expertise best suited for being the focal site. We really believe in interagency cooperation and I think that's important. The best approach would be to begin with home-based counseling which would lead to more standard levels of care at the Centers.

One thing that I would like to add is that the University of Iowa had federal funding for a model project on interdisciplinary casework teams servicing the elderly. Unfortunately these funds have been cut and the programs is basically floundering. It could have been really helpful!'"

"There was no question that the staff [Bronx, New York] thought CMHCs should be the major vehicle for the delivery of mental health services to older adults. They have the expertise and the resources

(although they need more resources), and there would be a lot of waste if the AAAs tried to give the mental health services. They felt there was no overlap in the Bronx between what the AAAs did and the five Bronx CMHCs did.

The CMHC is the major service in their area. The staff believes that one of its best features is that it can give a lot of services in one place, so that people do not have to go to many places and deal with fragmented services. For example, the #1 environmental problem is housing and the #2 is economic. The Center has a social services team, and when they find a person in need of housing they refer internally to the appropriate unit. The same is true with problems relating to Social Security or Supplemental Security Income, or Medicaid or Medicare."

"'We [Oxford, Mississippi] are the only agency who can do it - that is our role. What we are doing now is the way to go, if we don't have less funds, we'll be alright.

If the needs regarding the elderly become larger, we would be in a bind. The staff would have to be trained or else we'd put in a specialty staff. Many staff do not have an interest in working with elderly - but then, again, some don't like after-care, some are afraid of alcoholics. We are underserving many groups - if all the alcoholics walked in here, we'd be in real trouble.'"

SUMMARY OF AREA AGENCIES ON AGING INTERVIEWS

General

General discription of the Area Agency on Aging. Are any of the services offered mental health-related?

Four of the AAAs provide no direct services, but contract with other agencies for service delivery. Other AAAs provide mental health-related services, such as telephone reassurance, friendly visitors and widow support programs. In some cases, the AAAs provided space in their centers for CMHC mental health workers to meet with elderly clients. The following excerpts are illustrative of the range of services provided by the AAAs:

> "Of specific interest, the Council on Aging [Port Huron, Michigan] operates a small telephone reassurance program, (staffed by volunteers); a friendly visitor program (involving intitial outreach by professionals and followed-up by volunteers); a limited respite program; a 'brown bag' drug monitoring program; a seven-person 'outreach' program and a four-person 'information/referral' program (although the level of attention to psychological issues within these programs is somewhat unclear); pre-retirement workshops; 'As Parents Grow Older' support groups; and a 'Help Yourself' service information program. Several widow support groups are in operation, and a social worker at the local hospital has began an Alzheimer's support group. The AAA supports, under contract, two social workers at the Catholic Social Services Agency who provide psychosocial services to older persons in their homes. And, the transportation service is a vital support program."

> "'A muli-purpose agency [Oxford, Mississippi]; unit of local government we call a planning and development district. Provide no direct services, everything is contracted out. We have the basics: Nutrition program home delivered meals, transportation, homemaker services from Title III and Title XX. The In-home program is provided by a church-related group and Northern Mississippi Medical Center. The homemaker program is provided by the church group and some health aide by the hospital. The Information and Referral program is provided by the church group, and the ACTION program contracts for transportation. There is also a legal services program which was originally started with the law school and the young lawers division of the state bar.
>
> Sometimes mental health problems are picked up by the In-home worker; these are referred to a supervisor who makes contacts. There are two CMHCs with whom we've worked, trying to get funding for drug and alcohol programs for elderly but were not successful.'"

"The Agency [Spokane, Washington] is not a service delivery agency - there are seven full-time and one half-time employees. No funding is provided for mental health prevention."

"Within the catchment area the [Lynn, Massachusetts] AAA offers a range of social service, transportation, senior center services, nutrition, homecare programs, health education and an adult day care center. Among the services which are psychologically related are the outreach program; the social support service, which offers social counceling; case management, under the homecare program; and the CMHC elderly clinic, which is conducted on Mondays and Wednesdays in the Lynn Center."

"Two AAA-funded programs were visited [Naples, Floria]: Our Place Senior Citizen and the homeworker program of the local Department of Social Services. 'Our Place' serves between 100-125 older persons per week, providing congregate nutritional dining, social/recreational activities, and transportation -- all geared toward alleviating premature institutionalization of the aged. The homeworker program is staffed by one full-time program coordinator and nine half-time workers (the latter paid through Older American Act funds). The program serves about 300 persons per month."

"The funds are received by the [Abilene, Texas] AAA and subcontracts are let to various agencies (junior college, school systems, city and county units of government, a seniors citizens group) which provides the direct services (nutrition program, meals-on-wheels, health screening, volunteers, outreach, transportation and in-home services). There are 46 Senior Centers in 19 counties covered by this AAA. The only direct service provided by the AAA is I&R (intake and referral) on a call-collect whereby the caller is put in touch with the proper service-providing agency and then follow-up on the call is attempted. It is very rare that counseling is available at the Centers. Occasionally a seminar on widowhood or death and dying is arranged and the AAA encourages staff from the CMHC's to visit the Centers. Because of the lack of familiarity of the site directors with the mental health system, this is not usually followed up."

Does the AAA provide in-service training to staff and contractors or public education to others concerning mental health and aging?

Eight of the AAA sites visited offered some in-service staff training on the mental health problems of the aged. Most Agencies felt that the training was not as thorough or as frequent as it should be. The following comments are illustrative of the training provided through the AAAs:

"'The medical center [Oxford, Mississippi] and the staff of the contractor train in-home workers. Thorough training lasts a couple of weeks, and then they continue with in-service training. The nursing college also participates. There is a very low turn-over

rate in these personel. We also, in the past, have contracted with continuing education at the university for staff training. The state office provides AAA staff with a training period. USM provides occasional training to all AAA staffs, including, at times, problems of mental health. We do not train anyone.'"

"'Not in terms of mental health. We [Muscatine, Iowa] are planning a "listening skills" workshop at the meal sites for the older adults themselves and we would like to involve some staff members. If this is successful, we would like to do others on topics like stress and drug misuse or alcoholism.'"

"The staff [Bronx, New York] contracts out for Title IV Training. They do have in-service training for staff, but have limited time for it. The in-house staff works not in giving direct service but as consultants and contract managers, and so the training is not indepth training, but an introduction to psychiatric problems. The training is focused not on training them to give mental health services, but to do appropriate case management so that mental impairment can be recognized early and appropriate referrals made. The New York City Office on Aging has trained their contractors in New York City, in 125 nutrition sites and social services and New York State Community Services. The AAA is also training providers in the legal aspects of service. Training has been cut since the block grants. They used to have a catalogue of training problems; now they have one sheet. They previously employed consultants and trainers, and they are no longer able to do that."

"The AAA [Abilene, Texas] provides in-service training or arranges for appropriate personnel to do so. This is accomplished by coordinating these sessions with the various subcontractors. Also, there is an 'Abilene Coordinating Council' which pulls a variety of people together for training (e.g., the AAA staff attended a recent workshop on the grief process)."

"The staffs of these aging programs [Naples, Florida] programs receives some (but minimal) in-service training regarding the mental illness of the aged, primarily concerning the most severe psychopathology -- senility and psychosis. They receive little training regarding less severe psychopathology and normal psychological conflicts among the elderly. It does not appear they receive any training in active listening skills, empathy, or with problem-solving techniques."

Has this AAA conducted an assessment of the needs for mental health services among the elderly in the community? If so, what did the assessment reveal as to the prevalence of mental illness among the elderly and the types of services needed?

Only one AAA had conducted a formal needs assessment. The other aging agencies are aware of the needs of the aged population through their direct contact with the elderly and their contact with other service provider agencies. The following comments are illustrative of the responses received to the question:

> "'Yes, a needs assessment was done [Abilene, Texas]. The category called "Spiritual and Mental Well-being" was included but there was no evidence of prevalence of mental illness provided by this period. It was felt that generally, the people don't have the expertise to fill out an evaluation on mental health of themselves or others.'"

> "The [Bronx, New York] AAA has not conducted a formal needs assessment, but is aware of a number of the needs in the community. There are not enough accute psychiatric beds, as more emphasis is placed on the acute physically ill, rather than the emotionally ill. There are not adequate mobile units in the city. One big problem is that services are not designated for the elderly. Elderly don't utilize the geriatric community mental health clinics. There is a concern with dumping older people into foster homes where there is no treatment and there is victimization. The same is true for adult mentally disabled homes, as no services follow these clients into the homes. There is a need for shelter for persons who have been evicted, or lost their housing for other reasons."

> "'Yes, but nothing on mental health [Muscatine, Iowa]. Frankly, we were concerned that covering those types of issues would alienate older people. We simply didn't want a mental health image.'"

> "'Not as a separate assessment, just one or two questions included in other interviews. We [Oxford, Mississippi] have used students or older people themselves to do the surveys.'"

> "There has no assessment of needs of older persons for mental health services and there are no funds for such an assessment [Spokane, Washington]."

How would the AAA clients with mental health problems best be characterized?

The AAAs are able to identify a variety of mental health problems in their elderly clients. These problems included depression (the most frequently reported mental impairment), brain syndromes and dementias, and alcohol abuse. The following comments are illustrative of the range of mental health problems identified by the AAAs:

> "'A few depressive problems; very few alcohol problems, drug misuse probably exsist more than we know [Oxford, Mississippi].'"

"'Depression, agitation, senility and some hallucinations. It's actually a very wide variety of problems, with many of them being very severe [Muscatine, Iowa].'"

"'Loneliness is the most frequently identified psychological problem [Naples, Florida] -- sometimes the result of physical or psychological isolation and other times a manifestation of depression. The next most frequently identified problem was "over-medication" of the elderly by physicians and health programs which prescribe new/additional medications without reviewing current prescriptions, continue medications indefinitely, or use medications (rather than other interventions) because it is the quickest way to "complete" the service and get rid of the patient. It is estimated that 8% to 10% of the clients currently being seen have untreated alcohol abuse problems, as refected by the fact that this many clients have alcohol on their breath before noon (when seen in their homes or at communities Centers). They find few deinstitutionalized elderly in their community or referred to them by the state mental hospitals.'"

"Both CMHC and Area Agency on Aging [Lynn, Massachusetts] staff agree that the most common mental health problem experienced by their clients is depression. In most instances the depression is caused by loss of spouse, loss of job, retirement and other situational factors. Other common disorders are associated with dementia and alcohol."

"Some clients come from the Warm Springs Mental Hospital [Billings, Montana]. When they were released under the deinstutionalization program about seven years ago, they were put into group homes. Some of those elders now come to the Center, verbalize, and take part in activity. When they first attend, they may have problems, and if there are disturbing behaviors, the staff will refer them to the CMHC, and someone there will talk with the person."

"The [Bronx, New York] AAA does not provide service to known former mental patients. Their clients may have domestic squabbles, disabled spouses. They may be trauma victims, or rape victims. 'We see some people with organic brain syndrome. We make our referrals to CMHC's, or to Albert Einstein in the North Bronx. There is a special problem with these cases because the state hospital will no longer take admissions for organic brain syndrome, and the city hospital emergency rooms will not admit them because they have no place to send them. These older persons are excluded from services that they need. Most of the client come with concrete problems, which were not identified as mental health problems, but as environmental or situational problems.'"

Does the presence of mentally ill clientele have any impact on ongoing AAA programs? If so, what mechanisms would be required to overcome the problems posed by mentally ill clients?

None of the AAAs reported the presence of mentally ill participants as being disruptive to their programs. Aging agencies commented that severely emotionally impaired aged persons infrequently participate in agency programs as they are often homebound. Outreach programs were established in several agencies to identify elderly in need of mental health services and to refer them for appropriate treatment. The following comments are illustrative of the range of response by AAAs to mentally ill clients:

> "'Mentally ill persons have no impact on the programs here [Oxford, Mississippi].'"
>
> "'It was felt that the best way to deal with those problems is by educating the staff who have not been exposed to mental illness and are not aware of the referral possibilities [Abeline, Texas]. There has never been an instance where the CMHC has called a senior center to say that someone has been released from the Big Spring Mental Hospital and requests a follow-up by center staff. We don't call them and they don't call us.'"
>
> "'A major problem is really getting such people involved [Muscatine, Iowa]. So many of them are isolated shutins. We are beginning to work more closely with the CMHC in order to better serve such people. We also have one person who works part-time and does nothing else but follow-up on elderly people who have not become involved with our agency or who have discontinued their involment. That's how we find some of the more severly disturbed individuals.'"

Interaction With Other Agencies

An Area Agency on Aging may have ongoing relationships and interactions with other organizations that deal with elderly in the community, including CMHC's and other non-age-specific programs as well as the aging network. With what types of organizations does this agency interact on a weekly basis? With which organizations does the AAA have specifically designated liaison personnel? What is usually the nature of this agency's contact with other agencies? Which agency generally initiates contact?

All of the AAAs reported active, ongoing relationships with many other aging service, health, and community-based organizations. The following comments are illustrative of the organizational interaction and the varied nature of the contact:

"The [Detroit, Michigan] Area Agency does not tend to have a great deal of direct contact with mental health service agencies, (but this would not be expected). The Area Agency is, however, located in the same building as the Detriot-Wayne County Mental Health Administrative Board and staff from the two policy/administrative offices do regularly see and talk to each other (and a 'Building Ties' program has started to help further the linking between the two systems)."

"There are apparent coordination problems between the [Braddock, Pennsylvania] Adult Services Office and the Mental Health and Mental Retardation Office, and the line staff in both agencies are unable to work together effectively. This problem has increased since the MH/MR geriatric specialist left the Turtle Creek Valley Mental Health, Mental Retardation Office. In fact, the Adult Services Director felt that her programs had just began to work effectively with the MH/MR at the time the geriatric program was discontinued."

"[Abeline, Texas] CMHC - relatively little. The respondent stated that the reason this small contact occured at all was because her own husband worked at the CMHC.

State hospital - out of this particular region State Office of Mental Health - no senior Centers - the AAA monitors them and provides technical assistance. There are a moderate number of calls to the AAA regarding mental health problems of clients and the senior Centers.

Other AAA's - fairly large contact, fairly good exchanges. Mental health problems are very occasionally discussed. If a specific problem occurs with a client visiting from another area then there is cooperation.

Nursing homes - Yes?, enhance because an AAA staff member is on the Board of Directors of a nursing home. The AAA cooperates with the Texas Department of Health concerning the Ombudsman activities.

Private psychiatric hospital - there is none. There is a pastoral counceling center with which there are only indirect contacts.

Private MD's - no. The respondent indicated she would refer clients to the CMHC.

Human Resources - this office maintains close contact with the senior Centers. Many workers from Human Resources stop by Centers on a regular basis. They occasionally give seminars which, according to the respondent, are not usually too informative.

Law Inforcement Officials - Not much."

"There is weekly interaction with the Human Resources Development Council (the Community Action Agency) [Billings, Montana]. Fifty percent of their fuel assistance program clients are seniors.

People from the Council come to the Senior Center to assist with the weatherization program.

With the Welfare Department and the Yellowstone County Resource Development Agency there is collaboration on advocacy. There is a good relationship with the social workers in those agencies, and there are lots of referrals both ways.

The City/County Health Department provides nursing assistance for seniors. There is two way referral there also for both Meals-on-Wheels and the Senior Center.

There is two way referral with the Billings Housing Authority's subsidized housing program; Foster Grandparents and Senior Community Service Employment Program people work in the Senior Center; RSVP volunteer serve on the Crime Prevention Neighborhood Watch and the Crime Stoppers Program."

Has the Area Agency's interactions with other agencies that provide both general and categorical services to older people increased, decreased or remain the same since the implementation of the ADMS and Social Service block grants?

The AAAs are funded by an Older Americans Act appropriation through the Administration on Aging, and as such are not directly effected by the block grants. There has been indirect impact due to the block grants, however, as some service providers have had funding reduced, resulting in a shift in demand for service to the AAAs, and making it more difficult for the AAAs to locate referral sources for their own clients. The following excerpts illustrate the range of impact the block grants have had on the AAAs:

"'The block grants have probably helped us [Oxford, Mississippi] because we now have Title XX funds which we never had. The Welfare Department gives the block grant to the Council on Aging, which is very nice. The Community Action Agencies have lost a lot of staff, but have kept the ones which helped the most -- winterization, energy assistance, emergency food. We have had no cuts (or increases) in Title III. Other agencies seem to be more cooperative with us since they haven't been quite as independent.'"

"'Generally, it has increased but not really in relation to block grants [Muscatine, Iowa]. The Older American Act funds aren't blocked and also only 45% of those funds are federal, we really haven't noticed much block grant impact at all.'"

"The respondent [Abeline, Texas] indicated having heard there are a lot of cuts in funding and felt that meant a cut in services. This particular AAA notices the differences in the 'Call-for-Help' office gets many more calls and, in tern, has to make five or six times the former number of calls to make a successful referral."

"The Council on Aging [Billings, Montana] funding has increased since the block grants. There is more city and county money. The local politicians are becoming more aware of the needs of senior citzens. There was a state reorganization and reallocation of funds, and in this process Yellowstone got additional money. Yellowstone County has an increasing aging population, and that is why it is getting additional dollars."

"There has not been a direct change in funding since the block grants [Bronx, New York]. Title IV has been drastically cut. There is less training. Nutrition program funds were increased from state contributions. There is no money for new services, for training, or model projects or demonstrations."

<u>There is evidence that 50-75% of nursing home residents experience mental health problems but are unlikely to receive needed mental health services. Is the AAA involved in interceding on behalf of this group?</u>

There was considerable variation among the AAAs in their relationship to the needs of nursing home residents. Eight AAAs indicated an interest in working with nursing home residents, though several agencies were unable to establish programs due to financial constraints. The Aging Agencies were able to establish contact with nursing home residents in one or more ways, such as through ombudsman programs, visiting programs, and advocacy activity. The following excerpts illustrate the range of AAA involvment with nursing home residents:

"The Area Agency on Aging has been awarded an Administration on Aging [Lynn, Massachusettes] channeling grant with which they have established TLC (total long-term care). This is one of two national channeling demonstration programs on long-term care in the community. The program, which is primarily a research project, focuses on the coordination of health and social services. Mental health and services, provided by the elder clinic and CMHC, are available to TLC clients."

"'We [Muscatine, Iowa] do friendly visiting and also cooperate in nursing home placements and discharge planning.'"

"The AAA [Abeline, Texas] does not intercede for nursing home patients to receive better service. The funding is not available for this as it would require the full-time staff member."

"'Nothing beyond the ombudsman [Oxford, Mississippi]. We have been involved in advocacy in trying to get more legislation in the state because there is not any. We really have no authority in nursing homes; we want more access to them.'"

Other

Has the AAA had any increase or decrease in overall funding? If so, where have the changes occurred? What has been the impact of the funding changes on the AAA?

There was considerable variation in funding support for the AAAs. Several Aging Agencies reported recent increases in program and operating funds, others reported substantial budget reductions. The following comments illustrate the range of support received by the AAAs:

"'Our [Muscatine, Iowa] overall funding has increased particularly from United Way. This has more than offset a slight decline in federal funds.

There has been a few changes in who administrates what, but nothing very significant. Again, you should remember that our small size and nonreliance on federal funds probably make us a little unique.'"

'"Increases have occurred in community services block grants and local funds. Title XX increased for us [Oxford, Mississippi] also.

No impact on staff. Increases in services, slightly.'"

"The aging services in St. Clair County [Port Huron, Michigan] are strongly supported by the community through a special millage. A small but important portion of the program is 'at-risk' in that it is supported with funds under Title V of the Older Americans Act. There could be an 8-15% reduction in services in 1984, as OAA funding is not protected in Congress next year."

"They [Naples, Florida] are being asked by the local AAA to increase their array of services (to include home health aides, outreach, and meals, as well as homemaker services and chore services), to increase service delivery by 10%, to take a 13% cut in funding and to participate in 'open-competition' for the grant.

Clearly, all of the local professionals contacted acknowledged that they are not meeting all of the known needs of the elderly in their community. They expect this underservice to get worse in light of further funding cuts expected in next year's budget."

"There has not been a direct change in funding since the block grants [Bronx, New York]. Title IV has been drastically cut. There is less

training. Nutrition program funds were increased from state contribution. There is no money for new services, for training, or model projects or demonstrations."

"There was a $1 million decrease in federal funding and also a decrease in state support [Spokane, Washington]. As a result, there was a reduction in staff services, cuts in chore services from 25,000 hours of services in homes every month to 12,000. Client population was cut in half. There was reduced funding in some and termination in others, i.e., Hospice, widow counseling, senior newspaper."

"The Council on Aging [Billings, Montana] funding has increased since the block grant. There is more city and county money. The local politicians are becoming more aware of the needs of senior citizens. There was a state reorganization and reallocation of funds, and in this process Yellowstone got additional money. Yellowstone County has an increasing aging population, and that is why it is getting additional dollars.

The Yellowstone Council people did not think the private sector could pick up the tab for services when the federal government withdrew from funding. They felt the city and county would not, and the state could not. There opinion was that mental health 'is not popular.' There is much need for a better educational job. They have been talking with the county commissioners."

"The Adult Services Office [Braddock, Pennsylvania] has been able to maintain and expand funding levels since 1981, when the ADMS block grant program took effect. The state lottery program, which targets funds to aging programs, has generated 'windfall' revenues to the benefit of the county and local programs. However, even with increased funding the Adult Services Office believes that they do not have the capacity to handle the mental health problems of their clients."

The block grants are part of the Administration's inititive to shift responsibility for social programs to state and local government and to the private sector. In this state and community will non-federal sources be reponsive to the for mental health programs serving older Americans? In your opinion, what agencies would be most responsive?

The AAAs were consistent in their opinion that there would be little state and local government or private sector support for mental health if the Federal government should further reduce funding levels. The following excerpts are illustrative of the comments received:

"'None would really be too responsive to doing more than they already are [Muscatine, Iowa]. In some cases mental health has a negative stigma for funding agencies just as it does for older adults themselves. This can cause problems because we frequently use older

people as advocates for, or witnessess to, the needs for a particular program. So, in some cases, both older people and local community citizens on local funding boards just don't touch mental health.'"

"'I don't think they are going to pick up the whole thing [Oxford, Mississippi]. We have to do more advocacy with the legislature because they control. We have good relations with county boards so we receive a good bit of local money from them. Private funds are non-exsistent.

I believe the block grants may have helped mental health because they received some Title XX money.

The state meets the required match for the federal funds but no more than that.'"

"The respondent [Abilene, Texas] indicated she welcomed the federal involvement. She feels that her agency functions better when given a broad scope of services to be provided and are free to meet the needs whatever they are. She stated that from area to area the needs may vary and the state regulations are very restrictive about percentages of funds spent on the regulations they have formulated. She continued on to say that these regs usually apply more to Dallas, e.g. and they are 'hardput to follow them.' The Federal guidelines never presented a problem.'

"None of these programs [Lynn, Massachussets] feel that local governments or private cooperations and foundations can pickup the slack if there are further decreases in federal funding. At this time Area Agency on Aging is not facing drastic funding cuts."

Nationally, only 4% of the CMHC client population is elderly, although 11% of the overall population is over 65. What are some possible reasons for this? What role can/should the AAA play to reverse this trend?

The AAAs stated that the greatest barriers to the delivery of mental health services to the older persons are negative stereotypes and the lack of services designed to meet the needs of the aged. Negative stereotypes are held by mental health professionals regarding the aged, and by the aged regarding mental health services. The AAAs felt their role in helping to reduce these biases could be through public education efforts. The following comments are illustrative of the comments received:

"The director [Bronx, New York] believes the needs of the elderly have only become well focused in last few years. CMHC programs have been youth oriented and not enough was known about the emotionally disturbed elderly. CMHC's did not put a priority on services to the aged. This is now becoming important because of the aging of the nation's population; it is now a situation that can't be overlooked; it is disturbing in family life, in nursing homes, and in community life.

The medical community lacks an understanding of the total needs of older persons, and needs to be sensitized to the needs of the elderly and not see them as albatross, but as people."

"There is a reluctance on the part of older people to go for mental health service; CMHC people have always done home visits, but their ability to do this is now being curtailed [Billings, Montana]. 'The CMHC has been outstanding. They will come in an emergency -- Saturday, Sunday, at night -- whenever it is needed they will respond.'"

"'The main reason elderly don't go to the [Oxford, Mississippi] CMHC is because of families -- a stigma attach. Education of the public is needed. Attitude of the elderly: probably are ignorant of need for mental health help. Preparedness of staff at CMHC: I would hope so. I don't know. Probably not enough money to do the job. Role of AAA to reverse trend: Definitely can play a role. If you announce in the paper about a workshop on mental health, maybe hospital staff will go, but general public, no. Need to educate public.'"

"'Finances would be one of the most important factors along with negative stereotypes on both sides [Muscatine, Iowa]. Also, a reluctance to do home visits on the part of the CMHCs is particularly bad. The CMHCs also seem to be assessment and diagnosis oriented with little or no follow-up.'"

What organization in your community is the most appropriate to provide mental health services to older people?

The AAAs had differing opinions as to which community organization is the most appropriate for the delivery of mental health services to the aged. Several indicated that CMHC's were the appropriate organization to provide service, others felt that AAAs should either provide the mental health services or contract with other organizations for services, and other AAAs felt the appropriate service delivery organization was the local hospital. The following excerpts are illustrative of the comments received:

"It is their belief [Braddock, Pennsylvania] that the county MH/MR office should assume expanded responsibilities for mental health services to older adults."

"'We [Muscatine, Iowa] are probably the most logical choice because we can do it in-home or at activity centers and nutrition sites where older people already are and we can do it for free. We have a positive and trusting relationship with the older community. I would see CMHC's playing back-up support role particularly with the more severe problems.'"

"'The AAA [Abilene, Texas] can help in involving the older client with mental health clients in the mainstream, the respondent stated. As far as actually counseling a client, she felt a trained

professional was needed. Her opinion was that they could not provide comprehensive mental health services, perhaps preventive, but that was all. She felt that a trained person from the CMHC should rotate from center to center but without this the AAA had a very weak link.

She ended by saying if the Older Americans Act would improve funding so as to allow the AAAs to hire a mental health worker, they could provide that service.'"

"The CMHC [Billings, Montana] should be the agency to deliver mental health service because they have the training and the expertise. The area is fortunate to have the Older Adult Service, which does not have the 'crazy' image."

"The staff [Bronx, New York] thought that hospitals were the most appropriate agency to give mental health services to the elderly. While Fordham/Tremont is committed and has an excellent unit, as does Bronx Lebanan, services that come from a hospital psychiatric unit are the most desirable.

Many aging providers say that they should be providing services because the elderly would accept mental health services from the Aging Agencies, where they are getting other services.

Older people except referrals better in a medical setting. There should be mental health backup for senior citizens."

Section II

SURVEY OF COMMUNITY MENTAL HEALTH CENTERS

GENERAL INSTRUCTIONS

Please complete the following information and return no later than April 22.

Because there is no uniform date for the local start-up of the block grant program, you are asked to provide information based on your agency's accounting records. If possible, please provide 12 month data for both the pre-block grant period and the current period, please note in the comment box on page 3 and estimate full year figures based on program patterns year to date.

We are interested in obtaining information regarding your older clients. For purposes of uniformity, we are defining "older" as age 65 and over. If this information is incomatible with your records, please note the age break out (i.e., 60 or 55) which you use in the comment box on page 3 and complete the form based on your records.

Thank you for your prompt attention and reply. A return envelope is enclosed for your use.

I. GENERAL BACKGROUND INFORMATION

Has your Community Mental Health Center program been adversely affected due to the initiation of the federal ADMS block grant program? ____Yes ____No

If yes, in general, have the changes forced you to limit or change any of the following program functions? (Please check one or more).

_____Staff Support
_____Clinical Services
_____Administrative or Clinical Record Keeping
_____Other_____
_____

If so, please briefly state in your own words the nature and magnitude of the changes, who was affected, and how.

_____
_____
_____

II. AGING PROGRAM INFORMATION

Do you now have an identifiable aging program in your Center (i.e., services for people age 65 and over)? ____Yes ____No

Did you have an aging program prior to the block grant program? ____Yes ____No

If so, when did it exist?
From 19___ to 19___

III. FUNDING PATTERNS

	Current Budget	Pre Block Grant Budget
Please identify funding sources under each category and show totals from each source.		
Federal government funding sources		
_____	$_____	$_____
_____	$_____	$_____
Subtotal	$_____	$_____
State government funding sources		
_____	$_____	$_____
_____	$_____	$_____
Subtotal	$_____	$_____
Local governemnt funding sources		
_____	$_____	$_____
_____	$_____	$_____
Subtotal	$_____	$_____
Private funding sources		
_____	$_____	$_____
_____	$_____	$_____
Subtotal	$_____	$_____

Other

_____	$____	$____
_____	$____	$____
Grand Total	$____	$____

IV. CLIENT PROFILES

	Current Budget	Pre Block Grant Budget
A. Age and Sex		
Age 1 - 17	___Fem___Male	___Fem___Male
Age 18 - 64	___Fem___Male	___Fem___Male
Age 65 - over	___Fem___Male	___Fem___Male
B. Race/Ethnicity of Client Age 65 and over		
Number of:		
White (not of Hispanic origin)	___Fem___Male	___Fem___Male
Black (not of Hispanic origin)	___Fem___Male	___Fem___Male
Hispanic (regardless of nationality)	___Fem___Male	___Fem___Male
American Indian or Alaska Native	___Fem___Male	___Fem___Male
Asian or Pacific Islander	___Fem___Male	___Fem___Male

V. SERVICES

	Current Budget	Pre Block Grant Budget
A. Total Services		
What are/were total number of visits per year	_____	_____
What percentage of visits per year were by older people	_____%	_____%
B. Percentage of Services to Older Clients		
Percentage of direct care or treatment services to older clients (including inpatient, outpatient, partial hospitalization, crisis intervention/ emergency services)	_____%	_____%
Percentage of prevention, consultation and education services to older clients	_____%	_____%

Percentage of specialized services to older clients (including outreach, home care and case management). _____% _____%

VI. STAFFING PATTERNS

	Current Budget	Pre Block Grant Budget
A. Total staff		
Number of:		
Full time (at least 35 hrs) Professionals	_____	_____
Part time (less than 35 hrs) Professionals	_____	_____
Paraprofessionals (full and part time)	_____	_____
Support/clerical (full and part time)	_____	_____
Volunteers	_____	_____

B. Race/Ethnicity and Sex of Professional Staff (Full and Part Time)

Number of:		
White (not of Hispanic origin)	___Fem___Male	___Fem___Male
Black (not of Hispanic origin)	___Fem___Male	___Fem___Male
Hispanic (regardless of nationality)	___Fem___Male	___Fem___Male
American Indian or Alaska Native	___Fem___Male	___Fem___Male
Asian or Pacific Islander	___Fem___Male	___Fem___Male

VII. Would you agree to telephone interview at a later date? ____Yes ____No

If yes, please provide the following information:

Name_____
Title_____
Agency_____
Street_____
City, state, zip_____
Telephone: area code ____ ____ _____

Comments: (Please use this space to expand upon your remarks and to note any budgetary or record-of-age discrepancies in your response, as instructed under the general instructions on page 1 of this form).

_____
_____
_____
_____
_____

Section III

GUIDELINES FOR SITE VISIT INTERVIEWS

a. Interviews with Community Mental Health Centers.

b. Interviews with Area Agencies on Aging.

c. Interviews with Clients and/or Significant Others.

INTERVIEWS WITH COMMUNITY MENTAL HEALTH CENTERS

I. INTRODUCTION

Recently, this Community Mental Health Center participated in a survey sponsored by the National Council of Community Mental Health Centers and the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging. In opening the interview note that the survey represents the only nationwide effort assessing the impact of the Alcohol, Drug Abuse and Mental Health (ADMS) block grant program on the provision of mental health services to older Americans. The cooperation of this Center is vital to the success of this project, which may provide a basis for increased federal funding of CMHC's. Thank person for completing the questionnaire and for agreeing to interview.

II. IMPACT ON GENERAL PROGRAM

A. In general, how has implementation of the ADMS block grant program affected this Center?

B. Since the Center began receiving ADMS block grant funds, has the composition of its client population changed with regard to age, race or ethnicity, sex or employment status? If so, in what way and to what extent?

C. Has the general reduction in block grant appropriations resulted in the development or exacerbation of any problems at this Center? (For instance, it may be useful to explore effects of the block grant program on client waiting lists, case load averages, eligibility criteria and client fees.)

D. 1. The deinstitutionalization movement has generally resulted in increased demand for outpatient services nationally. Has this Center found this to be true within its catchment area? If so, what types of populations have increased within its caseloads as a result of deinstitutionalization? (Specify by age, race, sex, socioeconomic background.)

2. There is evidence that there is still a high population of older patients in state/county mental hospitals. Is this true in this catchment area? If true, what does the Center see as the major reason?

III. IMPACT ON AGING POPULATIONS

A. Nationally, only 4% of the client population of Community Mental Health Centers is elderly, although 11% of the general population is over 65. What does the Center perceive to be the major

reasons for underservice of this client population? Has the ADMS block grant program had any impact on the provision of mental health services to older people at this Center?

B. Has this Center conducted an assessment of the need for mental health services among the elderly in its catchment area? If so, what is the prevalence of mental illness among the elderly in this catchment area? What did the assessment reveal to be the most common mental health problems among older people in the community? (The following list is intended as a guide.)

Alcohol disorders
Drug disorders
Organic brain syndromes
Depressive disorders
Schizophrenia
Neuroses
Personality disorders
Childhood disorders
Transient situational disorders of adolescence, adulthood and late life
Social maladjustment
Other

C. NOTE: Interviewer will know if CMHC has an aging program, based on response to survey. If there is currently an aging program, use Version 1. If there was once an aging program but it has been discontinued, use Version 2. If the Center did not have an aging program, use Version 3.

Version 1. This Center has indicated that it has a specialized aging program. Specifically, what services are provided as part of the program? (The following are types of services that may be offered.)

Direct care or treatment services (including inpatient, outpatient, partial hospitalization, crisis intervention/ emergency services);

Prevention, consultation and education services;

Specialized services (including outreach, home care and case management).

Version 2. This Center indicated that it did have an aging program at one time. Why was the program discontinued? (Possible reasons to explore include discontinuation of funding, lack of community support, lack of utilization.)

Does this Center plan to reinstitute an aging program within the near future (i.e., within the next 3 years)?

Version 3. The Center indicated that it has never had an identifiable aging program. Why not? (Possible reasons to explore include staff attitudes toward the elderly, lack of staff training in regard to special mental health needs of older people, insufficient resources, reluctance of elderly to seek mental health servies.)

Did this Center at any time plan to develop an aging program? If so, why were the plans not implemented?

Does this Center plan to develop an aging program within the near future (i.e., within the next 3 years)?

IV. INTERACTION WITH OTHER AGENCIES

We are particularly interested in learning about the interactions between the CMGC and other community agencies, particularly AAA's and aging network and state/county mental hospitals. The following list is intended as a guide for discussing Section IV.

Area Agency on Aging
Multi-Purpose Senior Center/Nutrition Site
State Unit on Aging
Nursing Home/Long-Term Care Facility
State/County Mental Hospital
Private Psychiatric Hospital
Private Mental Health/Counseling Clinic
General Hospital/Outpatient Clinic
Private Physician
Department of Public Health
Social Welfare Office
Social Security Office
Law Enforcement Agency
Other

A. Note that Community Mental Health Centers may have ongoing relationships and numerous interactions with other community organizations that deal with the elderly.

1. With what types of community agencies does this Center interact on a weekly basis?

2. With which organizations does the Center have specifically designated liaison personnel?

3. What is usually the nature of the Center's interaction with other agencies regarding older adults?

Referral
Case Management
Clinical Consultation
Advocacy
Administrative
Other (Specify)

4. Which agency generally initiates contact?

5. Has the Center's interaction with aging agencies increased, decreased or remained the same since implementation of the ADMS and Social Service block grants?

B. There is evidence that 50-75% of nursing home residents experience mental health problems but are unlikely to receive mental health services. Is the Center involved in interacting on behalf of this group?

C. We are interested in learning how older clients are referred to the CMHC. Is this Center engaged in outreach efforts to recruit older clients?

Approximately what percent of older clients' contact with the Center is initiated in each of the following ways?

Discovered through CMHC's outreach
Referred to CMHC by other organizations or individuals in the community - Specify most common referral contact
Self-initiated contact

V. FUTURE DIRECTIONS

A. Block grants are part of the administration's initiative to shift responsibility for social programs to state and local government and to the private sector. In this state and community, will nonfederal funding sources be responsive to the need for mental health programs serving older Americans? In your opinion, what agencies would be most responsive?

State Government
County Government
Local Government
Private Corporations
Private Foundations
Other Private Nonprofit Organizations (i.e., Churches, Charities)
Other

B. Should the CMHC be the focal agency for the delivery of mental health services to older adults? Why or why not? If not, what would be the most appropriate agency?

INTERVIEWS WITH AREA AGENCIES ON AGING

I. INTRODUCTION

Recently, the National Council of Community Mental Health Centers and the Action Committee to Implement the Mental Health Recommendations of the 1981 White House Conference on Aging conducted a survey of Community Mental Health Centers. Note that the survey represents the only nationwide effort assessing the impact of the Alcohol, Drug Abuse and Mental Health block grant program on the provision of mental health services to older Americans. Since an Area Agency on Aging is likely to deal with a broader segment of the older population than that seen by the CMHC, the AAA is in a unique position to comment on the delivery of mental health services to older adults. Thank person for agreeing to interview.

II. GENERAL

A. Get a general description of the Area Agency of Aging, including an overview of services offered. Are any of the services offered mental health-related? (For instance, widowhood counseling and telephone reassurance, mental health education and prevention as well as more traditional counseling and intervention services.)

B. Does the AAA provide in-service training to staff and contractors or public education to others concerning mental health and aging?

C. Has the AAA conducted an assessment of the need for mental health services among the elderly in the community? If so, what did the assessment reveal as to the prevalence of mental illness among the elderly and the types of services needed?

D. How would the AAA clients with mental health problems best be characterized? (For example, are they any of the following: former or current state/county mental hospital patients, street people, boarding home residents or clients with problems related to bereavement and other situational crises?)

E. Does the presence of mentally ill clientele have any impact on ongoing AAA programs (such as senior centers, home care programs, outreach, information and referral, case management)? If so, what mechanisms would be required to overcome the problems posed by mentally ill clients?

III. INTERACTIONS WITH OTHER AGENCIES

The following list is intended as a guide for discussion of the questions in Section III. We are particularly interested in learning about the interaction between Area Agencies on Aging and Community Mental Health Centers, State/County Mental Hospitals and other components of the mental health and aging networks.

Community Mental Health Center
State/County Mental Hospital
State Office of Mental Health
Senior Centers
Other Area Agencies on Aging
Nursing Home/Long-Term Care Facility
Private Psychiatric Hospital
Private Mental Health/Counseling Clinic
General Hospital/Outpatient Clinic
Private Physician
Department of Public Health
Social Welfare Office
Law Enforcement Agency
Other

A. An Agency on Aging may have ongoing relationships and interactions with other organizations that deal with elderly in the community, including CMHCs and other non-age-specific programs as well as the aging network.

1. With what types of organizations does this agency interact on a weekly basis?

2. With which organizations does the AAA have specifically designated liaison personnel?

3. What is usually the nature of this agency's contacts with other agencies? (For instance, referral, case management, clinical consultation, advocacy, administrative, other.)

4. Which agency generally initiates contact?

5. Has the Area Agency's interactions with other agencies that provide both general and categorical services to older people increased, decreased or remained the same since implementation of the ADMS and Social Service block grants?

B. There is evidence that 50 - 75% of nursing home residents experience mental health problems but are unlikely to receive needed mental health services. Is the AAA involved in interceding on behalf of this group?

IV. OTHER

A. Has the AAA had any increase or decrease in overall funding? If so, where have the the changes occurred? (For instance: Older Americans Act grants; Social Services Block Grant; Community Services Block Grant; other federal, state, local or private funding sources.)

B. What has been the impact of the funding changes on the AAA? (You may wish to explore effects on staff, services, administration, etc.)

C. The block grants are part of the administration's initiative to shift responsibility for social programs to state and local government and to the private sector. In this state and community will nonfederal funding sources be responsive to the need for mental health programs serving older Americans? In your opinion, what agencies would be most responsive? [For example: State government, county government, local government, private corporations, private foundations, other private nonprofit organizations (i.e., churches and charities)]

D. Nationally, only 4% of the CMHC client population is elderly, although 11% of the overall population is over 65. What are some possible reasons for this? (Potential reasons to explore include staff attitudes toward the elderly, lack of staff training in regard to mental health needs of older people, insufficient resources and reluctance of elderly to seek mental health services.) What role can/should the AAA play to reverse this trend?

E. What organization in your community is the most appropriate to provide mental health services to older people? Please elaborate.

INTERVIEWS WITH CLIENTS AND/OR SIGNIFICANT OTHERS

I. INTRODUCTION

Thank person for agreeing to interview. Note that the person is contributing to a nationwide effort to assess the availability and adequacy of mental health services for older adults. This study will provide valuable information for both public and private sector policymakers. Representatives of the local Community Mental Health Center and the Area Agency on Aging have been interviewed; however, it is important to know how mental health services are perceived by the people who use them. The purpose of this interview is not to delve into the client's personal life, but rather to learn how mental health services might be improved to better meet the needs of older people.

II. CLIENT INTERACTION WITH COMMUNITY MENTAL HEALTH CENTER

A. What services does client routinely receive from the Community Mental Health Center? (Service offered may include counseling, crisis intervention, partial or full hospitalization, prevention, education, outreach, home care, case management).

B. How did client learn about the Community Mental Health Center?

C. Is client satisfied with the treatment or other services received? Why or why not?

III. CLIENT INTERACTION WITH AREA AGENCY ON AGING

A. What services offered by the Area Agency on Aging are utilized by the client? (Services offered may include: Nutrition program, Home Care Programs, Transportation, Ombudsman, Tax Counseling, Legal Services, Information and Referrals, etc.)

B. How did client learn about the Area Agency on Aging?

C. Is the client satisfied with the services received? Why or why not?

IV. GENERAL

A. In general, has client encountered any difficulties or frustrations in making use of services available through either the CMHC - or - the AAA? (Potential problems include transportation, excessive paperwork, insensitivity of staff, etc.)

B. Are there other services that client would like to see provided that are not currently available through either agency?

C. Has the client's family/significant other(s) been involved in any way with these programs? (Do they encourage client to seek

services, or help with paperwork? Do they provide transportation? Do they receive family support services?)

D. We are interested in learning who provides the most consistent source of support for the client. Who does the client most consistently rely on and/or turn to in an emergency?

Area Agency on Aging
Community Mental Health Center
Social Security Office
Other Community Service Agency
Family
Church/Synagogue
Friends
Law Enforcement Officials
Other

Section IV

LEVELS OF STATISICAL SIGNIFICANCE

1. Page 10: t (105) = 0.64, $p > .05$, using a two-tailed independent t-test.
2. Page 13: F (1,203 = 6.59, $P < .05$.
3. Page 13: F (1,190) = 4.86, $P < .05$].
4. Page 13: $F(1,60) = 5.70$, $p < .05$.
5. Page 13: $F(1,60) = 5.09$, $p < .05$.
6. Page 13: F (1,60) = 5.30, $p < .05$.
7. Page 13: [X^2 (1, N = 223) = 6.83, $p < .05$].
8. Page 13: [X^2 (1, N = 207) - 23.84, $p < 05$].
9. Page 14: pre-block grant: F (1, 140 = 0.17, $p > .05$.
10. Page 14: post-block grant year: F (1,155) = 0.45, $p > .05$.
11. Page 14: F (1, 125) = 2.34, $p > .05$.
12. Page 14: F (1, 146) = 0.01, $p > .05$.